STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505511	A. BUILDING _____ B. WING _____	C 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEON SULLIVAN HEALTH CARE CENTER	2611 SOUTH DEARBORN SEATTLE, WA 98144

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F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Complaint Survey conducted at Leon Sullivan Health Care on 10/31/13, 11/5/13, 11/6/13. A sample of 7 current residents from a total census of 144 was selected for review. The sample included 4 closed records. The survey was conducted by: [redacted]MN, RN, Complaint Investigator Complaints investigated include: #2886372; 2889334; 2890829; 2891059; 2895027; 2894983; 2899307 The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2, Unit D 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388 Telephone: (253)234-6000 Fax: (253)395-5071 Debra Lea 11-21-13	F 000		12-14-13

Received
DEC 06 2013
DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12-2-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	**F225** It is the policy of Leon Sullivan Health Care Center to protect residents and employees from abuse of any kind, investigate actual or potential abuses thoroughly and report to the appropriate departments in a timely manner. The facility has a "zero" tolerance for abuses. **Actions Taken for the alleged abuse reported by the resident involved.** 1. The alleged Perpetrator (NAC) was suspended pending the investigation. 10-01-2013 2. The Resident this NAC cared for was assessed and placed on alert charting for possible physical or psychological harm. No concerns or change in condition were identified. 10-01-2013 3. Physician, family, SPD, Hotline and Administrator were notified of the incident. 10-01-2013 4. Incident investigation was completed by the resident care manager and filed 10-05-2013. Investigation report is available upon request. 5. Staff H, J and K have been in-serviced on abuses and abuse reporting policies and procedures-11-22-2013 **Measures taken to ensure solutions to this incident are sustained and recurrence prevented.**	12-10-13

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure an allegation of abuse was reported immediately according to state law and did not initiate an investigation until 5 days after the report for 1 of 3 allegations of resident abuse reviewed from a census of 144. This placed all 144 residents at risk for further potential abuse. Findings include: Record review found Resident #4 was last admitted to the facility [redacted]/13 with multiple medical conditions resulting in difficulty walking. Resident #4's minimum data set (MDS) assessment dated 9/9/13 identified the resident had moderate cognitive impairment and required limited one person assistance with most activities of daily living. On interview 11/5/13 at 11:55 a.m. Staff H stated Resident #4's reported the following events to her on Thursday 9/26/13: Staff J called her derogatory names "blackie" and "pinky" for several weeks. Resident #4 asked Staff J to call her by her given name, but he continued to use the derogatory names. Staff J hit her on the shoulder. Staff H stated she identified the resident's report as abuse and told her supervisor Staff K right away. Staff H identified she should report abuse to the hotline as directed by the information printed on the back of her name badge. According to Staff H, she did not call the hotline because a) she did not see the abuse, b) at that time it was the resident's word against staff, c)	F 225	F225 Continued Because all residents are potentially affected by this cited deficiency, for resident #4 and all, under the direction of Social Services Director, all staff will be in-serviced on: 1. Abuses and abuse reporting policies and procedures on 12-10-2013. 2. The importance of checking criminal background prior to hiring employees. 3. Culturally in-appropriate comments (jokes) 4. Potential consequences of failure to report abuses to the concerned departments and individuals in a timely manner. The facility believes that failure to report abuses immediately to the appropriate department can result in physical and psychological harm and fine. **Monitoring** 1. Resident Care managers/ department heads are responsible for training their employees as a group or on- one - on-one bases. 2. Quizzes related to abuses and abuse reporting procedures will be included in every other payday paychecks. This is usually on the 25th of each month. The need for further training is	12-14-13 12-14-13 12-14-13 on going

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F 225	Continued From page 3 sometimes residents say things. Staff H stated she assumed Staff K would go and talk to Resident #4, but this did not happen. An investigation was not initiated by anyone at the facility. According to Staff H when she found out no one talked to Resident #4 about the allegations, she immediately told Staff E (social worker), who initiated the investigation on 10/1/13 (5 days after the initial report). Staff K is the Staff Development coordinator for the facility, responsible to teach all staff the law and facility policy on abuse reporting. Staff K was on leave and not available for interview. Facility incident report (IR) review found on 10/1/13 the facility initiated investigation including suspension of Staff J pending investigation completion. Timecard review found that Staff J worked 4 days from 9/26 to 10/1/13 (9/26, 9/27, 9/28, 9/29). Failure to initiate investigation when initially reported resulted in further exposure of residents to potential abuse. Observation 11/5/13 at 12:55 p.m. found Resident #4 seated in a wheelchair in her room. The resident repeated her statement about Staff J hitting her shoulder and calling her "blackie" and "pinky". Staff J said that she told Staff H about it but nothing happened until Staff E and B (resident care manager) talked to her. Resident #4 said she was fine at the facility as long as staff call her by her given name. Failure to report and respond to alleged abuse resulted in delayed investigation and exposure of residents to potential abuse.	F 225	F225 Continued determined based on the results of these quizzes. 3. DON reviews all concerns and incident reports daily to ensure policies and procedures are followed and sustained. On weekends, the DON monitors incidents by phone. Compliance is reviewed in a Quarterly CQI meetings for further recommendation. **F281** Providing residents with quality of services according to professional standard of care is one of Leon Sullivan Health Care Center's policies. **Immediate Actions taken in response to the identified deficiency.** 1. Resident was placed on 24-our alert charting for observation 2. Skin assessment conducted 3. Family and physicians were notified of the incident and delay in removing sutures. 4. Order to remove the sutures obtained 5. Sutures above the (R) eye were removed- skin intact, no s/s of infectious process noted. Vital signs were within normal limits. 6. Staff A and N were in-serviced on the importance of carrying out physicians	

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F 281	Continued From page 4	F 281	281 continued	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement a functional system to ensure all doctor orders are processed and followed. One of 8 sample residents (#1) reviewed for care from a census of 144, should have had sutures removed from an eye laceration and this procedure was not done. This resulted in sutures remaining place for 20 days longer than prescribed. Findings include: Observation 10/31/13 at 4:00 p.m. and 11/5/13 at 12:30 p.m. noted Resident #1 had sutures in place over the [redacted] eye. Medical Record review found Resident #1 received 5 stitches just above the right eye on 10/11/13 after sustaining a cut after a fall. Discharge instructions from the hospital included "Please see you primary care provider in 5-6 days to remove the 5 sutures in your laceration." There was no evidence in the resident record that this order was processed. Review of treatment records and progress notes no documentation in the resident's record as to when the stitches were placed, or if they needed removal or were scheduled for removal.	F 281	orders and follow up with recommendations from clinical appointments and consultants in a timely manner. 11/6/2013. **Measures taken to ensure solutions to the identified deficiency are sustained and recurrence prevented.** All residents are potentially affected by the cited deficiency Under the direction of DON, all LNS will be in-serviced on: 1.The importance of reviewing recommendations from all internal departments, notifying primary physicians of outside clinic appointments and consultants' recommendations immediately. 2. Head- to-Toe assessment, interviewing residents, listening to their concerns and documenting findings in medical records and follow up. 3. On potential consequences of delay in processing physicians' orders as with resident#1.Infection can be one of the potential Consequences of not removing suture as ordered. **Improving system** The facility will Place two folders on each unit. One for yellow copies of physicians order and the other for all recommendation from other departments/hospitals. The RCMS will check both folders every day to ensure	12-14-13 12-14-13 12-14-13

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F 281	Continued From page 5 Nursing staff documented weekly skin checks on Tuesday evenings. On 10/22/13 and 10/29/13 staff documented - (no skin issues). There was no documentation of wound size/character or depth anywhere in the record. On interview 11/6/13 at 8:30 a.m. Staff A (resident care manager) said that facility nursing staff missed monitoring Resident #1's wound and did not schedule removal of the sutures because there was not a good system to ensure this was done. The facility failed to implement a functional system to ensure all doctor orders are processed and followed. Resident #1 was in need of sutures removal from an eye laceration and this procedure was not done.	F 281	281 continued policies and procedures of processing physicians' orders are sustained. **Monitoring** 1. Resident Care Managers will review all physicians order daily Monday-Friday. LNS will be trained on how to review and transcribe physicians' orders so that they can help on the weekends or as needed. 2. Any new orders or recommendations that need to be processed in the future such as removal of sutures will be placed on the computer with a warning sign attached as a reminder. The computer will alert the LNS on/or before the due date. 3. Using the audit tools, the DON/designee will review physicians' orders quarterly and as needed to ensure the process in place is followed and sustained. Compliance will also be reviewed in a quarterly CQI meeting.	on-going
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 1 of 8 sample residents (#1) reviewed for care from a census of 144 received wound monitoring and suture removal for a cut with sutures. This resulted in	F 309	**F309** Skin/wound care is one of the top priorities in the facility. All wounds in the facility- community or in-house acquired are assessed and care planned for immediately per house policy. **Immediate Actions taken in response to the cited deficiency.** 1. Skin assessment done and sutures were removed by staff #N	

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F 309	Continued From page 6 sutures staying in place for 20 days after removal was to be done. Findings include: Record review found Resident #1 was last admitted to the facility 6/4/13 with medically disabling conditions and Dementia. Resident #1's quarterly minimum data set (MDS) assessment dated 10/9/13 identified the resident was able to walk independently and used a walker. Resident #1's care plan identified the resident was at risk for falls. On observation 10/31/13, Resident #1 was lying on his bed in his room. Sutures were observed above the right eyebrow in the temple area. Resident #1 pointed to his sutures and said he was injured in a fall. "I fall all the time" the last time being a week ago. On observation 11/5/13 at 12:30 p.m. Resident #1 was seated in the hallway outside the dining room. The stitches over Resident #1's right brow were still present. Resident #1 pointed to his stitches and said "They don't pay me no mind." On interview 11/5/13 at 12:35 Staff C (licensed practical nurse) stated that she did not know anything about Resident #1's stitches, she would have to look in the record. Review of Resident #1's record found no documentation as to when the stitches were placed, or if they needed removal or were scheduled for removal. There was no documentation on treatment records or progress notes that nursing staff was monitoring the wound for healing	F 309	F309 continued 2. Resident was placed on alert charting to monitor Suture site for possible infection. 3. Direction to monitor (R) wound site every shift added to the TAR. 4. Pain assessment was done and documented. 5. See also F281 for immediate actions taken related to this citation. 6. Staff A was verbally counseled by the Administrator. 11-06-2013 **Measures taken to ensure solutions to this citation are sustained and recurrence prevented** Because all residents are potentially affected by this identified deficiency, under the direction of wound nurse, all Nursing staff will be in serviced on: 1. Skin assessment and wound care policies and procedures 2. Processing physicians' orders and consultants' recommendations 3. Inter/intra department communications 4. Preventative skin care and care plans. 5. Importance of communicating with residents and listening to their concerns. 6. Visual inspection and reporting changes in residents skin Integrity or changes in Conditions.	12-14-13 12-14-13 12-14-13 12-14-13 12-14-13 12-14-13

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F 309	Continued From page 7 An incident report dated 10/11/13 included a medical record identifying the stitches were placed at the emergency department after the resident was found down in the community. Directions included "Please see you primary care provider in 5-6 days to remove the 5 sutures in your laceration." On interview 11/6/13 at 8:35 a.m. Staff A (resident care manager) stated Resident #1 returned to the facility after the sutures were placed on Friday 10/11/13. According to Staff A, there was not a good system of communication to ensure the directions were added to the treatment record for wound monitoring and suture removal. According to Staff A, the original medical record from 10/11/13 was removed from the nurse's station and added to the incident report without leaving a copy in the resident's file. Staff A said he assumed the stitches were dissolvable.	F 309	F309 continued **System improvements** 1. All physicians' orders and consultant recommendations/referrals will be placed in the designated folders and be checked by the RCMS daily and processed accordingly with no delay. 2. RCMS/LNS are responsible for calling the hospital or clinics and obtain discharge summery or recommendations every time the resident comes back to the facility from appointment or following procedures. 3. Skin assessment will be done on all residents that return back to the facility from clinic appointments or following procedures. **Monitoring** 1. RCMS will audit daily charts of all residents that have been to clinics for procedures to ensure orders or recommendations are processed in a timely manner. 2. NACs will report any change in skin condition or unusual observation to the LNS on duty. This is an ongoing process. 3. Weekly skin checks on shower days can be used as one way of monitoring skin issues. 4. IDT will make rounds every Friday to monitor skin issues and progress in wound treatment. Compliance will be monitored by the Wound/skin nurse and discussed in a quarterly CQI meeting.	on-going on going on-going